

**STANDARD FORM FOR  
EMPLOYER'S SUPPLEMENTAL  
REPORT OF INJURY**

Approved by I. A. I. A. B. C.

**FLORIDA INDUSTRIAL COMMISSION  
TALLAHASSEE, FLORIDA**

**MARYLAND CASUALTY COMPANY  
JACKSONVILLE CLAIM DIVISION  
Suite 8-B, Atlantic National Bank Annex Bldg.,  
JACKSONVILLE, FLORIDA**

State's Number For:	File: _____ Carrier: _____ Employer: _____
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Carrier's File No. _____ (The spaces above not to be filled in by Employer)
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If Employer's First Report of Injury did not show that the injured had returned to work, an Employer's Supplemental Report of Injury should be completed and filed immediately after return to work of the employee; or at the end of \_\_\_\_\_ days. In the event of the death of the employee, this report should be filed immediately.

1. Name of Employer. Newark Eagles Baseball Club
2. Office address: No. and St. 71 Crawford St. City or Town Newark State N.J. Jersey
3. Insured by MARYLAND CASUALTY COMPANY
4. Name of Injured (in full) Lary Eugene Doby  
(First Name) (Middle Initial) (Last Name)  
285 Hamilton Ave. Patterson N.J.
5. Present address: No. and St. 285 Hamilton Ave. Patterson N.J.
6. Date of Injury April 1st 46 Day of week Monday Hour of day A. M. P. M.
7. Date disability began 19 A. M. P. M.
8. Has injured returned to work? yes If so, date and hour few days later A. M. P. M.
9. Is injured person earning same wages as before injury? If not, explain
10. If disability has not terminated, state probable date of termination of disability
11. Has injured died? If so, date of death A. M. P. M.

The injured employee, Lary Eugene Doby, returned to work April 6th, 46. The accident was not serious, and was only reported because it was necessary to have an X-Ray picture taken to determine the extent of any injury. No claim for compensation is being entered.

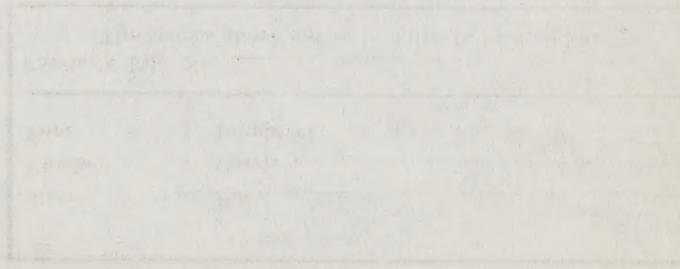
Date of this report \_\_\_\_\_ Firm name \_\_\_\_\_

Signed by *J. J. Manley* Official Title *Partner*

RECEIVED

MAY 23 1946

Jacksonville Cl. Div.



СОВЕТСКАЯ  
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